MUNICIPAL PLAN COMPARISON TEMPLATE (AS OF JULY 1, 2009)

Indemnity, PPO Options For Employees and Non-Medicare Retirees & Survivors:

	Municipal Plan		GROUP INSURANCE COMMISSION PLANS								
			Harvard Pilgrim Health Care Independence Plan		Tufts Health Plan Navigator		UniCare State Indemnity Plan/Community Choice	UniCare State Indemnity Plan/Basic (With CIC)	UniCare State Indemnity Plan/PLUS		
Plan Type	**POS**		**PPO**		**PPO**		**PPO-type**	**Indemnity**	**PPO-type**		
Coverage Area											
Not Available In These Counties			Available throughout Massachusetts		Dukes and Nantucket		Dukes and Nantucket	Available throughout the U.S. and outside of the country	Available throughout Massachusetts		
Key Cost Features											
Monthly Premium											
Individual			$526.29		$519.07		$411.28	$767.55	$532.44		
Family			$1,273.72		$1,250.70		$987.06	$1,791.79	$1,270.66		
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**			**In-Network**	**In-Net/OutsideMA**	**Out-of-Network**
Calendar Year Deductible			***Note:*** *Deductibles for mental health and substance abuse services accumulate separately from the deductibles for other medical services*								
Individual			None	$150 outpatient; Emergency room services do not apply	None	$150	None	None	None		$100
Family			None	$300 outpatient; Emergency room services do not apply	None	$300; Two members of a family must satisfy a $150 member deductible	None	None	None		$200
Out-of-Pocket Maximum											
Individual			None	$3,000; Doesn't include copays for office visit, hospital, ER, drugs or for skilled nursing facility coinsurance	None	$3,000	$750; Applies to home health care, prosthetics, braces and allergy serum	$750; Applies to home health care, prosthetics, braces and allergy serum	$750; Applies to home health care, prosthetics, braces and allergy serum		$3,000
Family			N/A	N/A	N/A	$3,000	N/A	N/A	N/A		N/A
Lifetime Maximum											
Individual			None	None	None	None	None	None	None		None
Family			None	None	None	None	None	None	None		None
Physician's Office Services											
Primary Care Physician Office Visit Copay											
***Tier 1 (Excellent)			$15 copay	20% after annual deductible	$15 copay	20% after annual deductible	$10 copay	$10 copay	$10 copay		20% coinsurance after the applicable O.V. copay, per visit, and after the annual calendar yr. deductible
**Tier 2 (Good)			No tiering	20% after annual deductible	No tiering	20% after annual deductible	$25 copay	$25 copay	$25 copay	Only MA. Doctors tiered; outside MA., 100% coverage after $25. copay	20% coinsurance after the applicable O.V. copay, per visit, and after the annual calendar yr. deductible
*Tier 3 (Standard)			No tiering	20% after annual deductible	No tiering	20% after annual deductible	$30 copay	$30 copay	$30 copay		20% coinsurance after the applicable O.V. copay, per visit, and after the annual calendar yr. deductible

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network			In-Network	In-Net/OutsideMA	Out-of-Network
Physician's Office Services Continued Specialist Care Physician Office Visit Copay ***Tier 1 (Excellent)			$15 copay	20% after annual deductible	$20 copay	20% after annual deductible	$20 copay	$15 copay	$20 copay		20% coinsurance after the applicable O.V. copay, per visit, and after the annual calendar yr. deductible
**Tier 2 (Good)			$30 copay	20% after annual deductible	$30 copay	20% after annual deductible	$25 copay	$25 copay	$25 copay	Only MA. Doctors tiered; outside MA., 100% coverage after $25. copay	20% coinsurance after the applicable O.V. copay, per visit, and after the annual calendar yr. deductible
*Tier 3 (Standard)			$40 copay	20% after annual deductible	$40 copay	20% after annual deductible	$40 copay	$35 copay	$40 copay		20% coinsurance after the applicable O.V. copay, per visit, and after the annual calendar yr. deductible
Services provided in a Retail Clinic Outpatient Visit			$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay		$15 copay
Hospital Services Emergency Room			$75 copay	$75 copay	$75 copay	$75 copay	$75 copay	$75 copay	$75 copay		$75 copay
Copay Waived if Admitted?			Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes
Per Admission Tier 1			$250 copay	20% after annual deductible	$300 copay	20% after annual deductible	$250 copay	$200 copay	$250 copay		$500 copay plus 20% coinsurance
Tier 2			$500 copay	20% after annual deductible	$700 copay	20% after annual deductible	N/A	N/A	$500 copay		
Tier 3			$750 copay	20% after annual deductible	N/A	20% after annual deductible	N/A	N/A	$750 copay		
Copay Limits			Maximum of four copays per calendar year; Waived if readmitted within 30 days	None	Maximum of four copays per calendar year; Waived if readmitted within 30 days	None	One admission copay during any given quarter of the year; Copays are waived for readmissions within 30 days of discharge	One admission copay for during any given quarter of the year; Copays are waived for readmissions within 30 days of discharge	One admission copay during any given quarter of the year; Copays are waived for readmissions within 30 days of discharge		None

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network			In-Network	In-Net/OutsideMA	Out-of-Network
Hospital Services Continued											
Outpatient Surgery			$150 copay	20% after annual deductible	$150 copay	20% after annual deductible	$100 copay	$100 copay	$100 copay (Tier1) $100 copay (Tier2) $250 copay (Tier3)		$100 copay then 20% coinsurance
Copay Limits			Four copays per calendar year	None	Four copays per calendar year	None	One outpatient surgery copay per quarter of the year	One outpatient surgery copay per quarter of the year	One outpatient surgery copay per quarter of the year		None
Diagnostic X-Ray and Lab Service			$75 copay for high-tech imaging services (MRI, CT, PET Scan) Max. of one copay per member/per day; No copay for routine X-Rays and labs	20% after annual deductible	$75 copay for high-tech imaging services (MRI, CT, PET Scan) Max. of one copay per member/per day; No copay for routine X-Rays and labs	20% after annual deductible	$75 copay for high-tech imaging services (MRI, CT, PET Scan) Max. of one copay per member/per day; No copay for routine X-Rays and labs	$75 copay for high-tech imaging services (MRI, CT, PET Scan) Max. of one copay per member/per day; No copay for routine X-Rays and labs	$75 copay for high-tech imaging services (MRI, CT, PET Scan) Max. of one copay per member/per day; No copay for routine X-Rays and labs		20% after annual deductible
Rehabilitation Hospital			No copay	20% after annual deductible	No copay	20% after annual deductible	$200 copay	$150	$200 copay		$400 copay then 20% coinsurance
Benefit Limits			No limits	No limits	No limits	No limits	No limits	No limits	No limits		No limits
Skilled Nursing Facility Copay			20%	20% after annual deductible	20% copay	20% after annual deductible	20%; Does not count toward the annual out-of-pocket maximum	20%	20%; Does not count toward the annual out-of-pocket maximum		
Benefit Limits			45 days; Combined in and out of network limit		45 days; Combined in and out of network limit		45 days; Combined in and out of network limit	45 days	45 days; Combined in and out of network limit		
Physical Therapy & Occupational Therapy											
Physical Therapy			$15 copay	20% after annual deductible	$15 copay	20% after annual deductible	$10 copay	$15 copay	$15 copay		$15 copay
Annual Visit Limits			Up to 90 consecutive days following illness or injury		30 visits per calendar year		None	None	None		None
Occupational Therapy			$15 copay	20% after annual deductible	$15 copay	20% after annual deductible	$10 copay	$15 copay	$15 copay		$15 copay
Annual Visit Limits			Up to 90 consecutive days following illness or injury		30 visits per calendar year		None	None	None		None
Chiropractic Services											
Chiropractic Office Visit			$15 copay	20% after annual deductible	$15 copay	20% after annual deductible	$10 copay then 20% coinsurance; $40 maximum reimbursement per visit	20% coinsurance	$10 copay then 20% coinsurance; $40 maximum reimbursement per visit		
Annual Visit Limits			20 visits per year	20 visits per year	20 visits per year	20 visits per year	20 visits per year	20 visits per year	20 visits per year		

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Mental Health Services											
Separate Mental Health Deductible			Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes
Mental Health Calendar Year deductible			None	$150, Single $300, Family	None	$150, Single $300, Family	None	$150, single $300, family	None		$150, Single $300, Family
Mental Health Out of Pocket Maximum			$1,000, Single $2,000, Family	$3,000 per member	$1,000, Single $2,000, Family	$3,000 per member	$1,000, Single $2,000, Family	$3,000 per member	$1,000, Single $2,000, Family		$3,000 per member
In-patient treatment			$200 copay; Maximum of four copays per year	$150 copay then 20% copayment after annual deductible	$200 copay; Maximum of four copays per year	$150 copay then 20% copayment after annual deductible	$200 copay; Maximum of four copays per year	$150 per quarter inpatient copay	$200 copay; Maximum of four copays per year		$150 copay then 20% copayment after annual deductible
Annual Visit Limits			None	None	None	None	None	None	None		None
Out-patient treatment			$10 for group visits; $15 for individual visits	20% after deductible for visits 1-15; 50% after deductible for visits 16 and after	$15 for individual/family; $10 for medication management; $10 for group therapy	20% after deductible for visits 1 through 15, 50% after deductible for visits 16 and over	$15 for individual/family; $10 for medication management; $10 for group therapy	$15 for individual/family therapy; $10 for medication management; $10 for group therapy	$15 for individual/family; $10 for medication management; $10 for group therapy		20% for visits 1-15; 50% for visits 16+
Annual Visit Limits			None	None	None	None	None	None	None		None
Pharmacy Services											
Retail Copay (30 day supply)											
Tier 1			$10	No Benefit	$10	No Benefit	$10	$10	$10		No Benefit
Tier 2			$25	No Benefit	$25	No Benefit	$25	$25	$25		No Benefit
Tier 3			$50	No Benefit	$50	No Benefit	$50	$50	$50		No Benefit
Mail order Copay (90 day supply)											
Tier 1			$20	No Benefit	$20	No Benefit	$20	$20	$20		No Benefit
Tier 2			$50	No Benefit	$50	No Benefit	$50	$50	$50		No Benefit
Tier 3			$110	No Benefit	$110	No Benefit	$110	$110	$110		No Benefit
Routine Vision Care											
Coverage			Yes		Yes		Yes	Yes	Yes		
Frequency			Once every 24 months		Once every 24 months		Once every 24 months	Once every 24 months	Once every 24 months		
Member Responsibility			$15	20% after annual deductible	$15	20% after annual deductible	Ophthalmologist: Tier 1 $20; Tier 2 $25; Tier 3 $40; Optometrist copay: $25	Ophthalmologist: Tier 1 $20; Tier 2 $25; Tier 3 $40; Optometrist copay: $25	Ophthalmologist: Tier 1 $20; Tier 2 $25; Tier 3 $40; Optometrist copay: $25		
Additional Services											
Does plan cover infertility services?			Yes		Yes		Yes	Yes	Yes		
Frequency limitations on infertility services			Lifetime limit of 5 ART cycles per person		When approved in advance covers a maximum of 5 ART cycles per person, per lifetime		Maximum lifetime limit of 5 ART cycles per person per lifetime	Maximum of 5 ART cycles per person per lifetime	Maximum limit of 5 ART cycles per person per lifetime		
Does plan cover other reproductive services including birth control and abortion services?			Yes		Yes		Yes	Yes	Yes		
Hearing Aid Benefit			Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500		Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500		Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500	Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500	Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500		
Ambulance Service			None	20% after annual deductible	None		None	None	None		
Gym Membership Benefit			None		$150 gym membership reimbursement per household		None	None	None		

The information contained in this spreadsheet is for illustrative purposes only and based on publicly available information. The detailed plan design information for the Group Insurance Commission (GIC) plans and/or the municipal plan(s) has not been approved by either the GIC or the GIC's insurance carriers or by the municipality or the municipality's insurance carriers. With respect to the GIC benefits shown, complete information about specific benefits is contained in the "Summary Plan Descriptions" (known as the GIC's health plans' "Plan Handbooks") for each program, which are available from the GIC. More detailed information about a municipality's plan may be obtained from the municipality. Boston Benefit Partners, LLC does not represent or warrant that the information provided herein specifically reflects any program.